RAI Version 2.0 Questions and Answers

Preface

This Question and Answer document contains 49 question/response sets, based on questions directed to the Health Care Financing Administration (HCFA) Central Office concerning the Resident Assessment Instrument (RAI) version 2.0. This document begins with a few general questions about the RAI process and the remaining questions are arranged by section of the RAI forms. This is the second Question and Answer compilation document for version 2.0 formally published by HCFA. As such, the question/response sets in this document are numbered 2 - 1 through 2 - 49. The first compilation document was published in August, 1996. The two Question and Answer compilation documents, as well as individual Q & A's and sets of Q & A's linked to HCFA satellite broadcasts can be downloaded from HCFA's MDS web site at: www.hcfa.gov/medicaid/mds20/res_man.htm. We are targeting a release of another compilation Q & A document by late spring.

This compilation of Q & A's is published by HCFA and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term care facilities. This is intended to be an adjunct to the Long Term Care RAI User's Manual, version 2.0, October, 1995.

This Q & A document was compiled by HCFA Central Office staff: Sue Nonemaker, Cindy Hake, Dana Burley, Sheila Lambowitz, Lisa Hines, Yael Harris, Dorothea Musgrave, Susan Burris and Jeane Nitsch. Special thanks are given to Dr. John Morris, Dr. Katharine Murphy, and Pauline Belleville-Taylor of the Hebrew Rehabilitation Centre for the Aged; Dr. Courtney Lyder of Yale University; Lynn Steele of the CDC; and Dr. Bob Godbout of Stepwise Systems, for their input on these materials.

Please refer any additional clinical or MDS automation questions to the RAI Coordinator in your State. State RAI contacts are published on HCFA's MDS web site at: www.hcfa.gov/medicaid/mds20/state.htm Questions that cannot be resolved at the State level should be referred to the HCFA Regional Office RAI Coordinator. Questions that cannot be resolved at the Regional level should be referred to HCFA's Central Office:

MDS Coordinator
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Mail Stop S2-12-25
Baltimore, MD 21244

PPS questions should be referred to the facility's Medicare Fiscal Intermediary.

Thank you for your continued enthusiasm in implementing the RAI version 2.0.

General Questions about the RAI Process

QUESTION 2 - 1: Frequently, the nursing homes I work with have questions regarding coding of the MDS for Medicare payment purposes. When we question our Medicare reimbursement representative, we do not always agree with her interpretation of MDS item-by-item definitions and coding conventions. We are left wondering if the MDS is primarily a tool for quality monitoring or reimbursement; depending on the emphasis, could MDS assessments be skewed as a result?

The RAI was designed first and foremost as a comprehensive assessment tool to be used by clinicians in designing individualized care plans and programs for the residents they serve. Adherence to item definitions and the proper time period for observation of the resident's status as determined by the assessment reference date is critical to ensure the accuracy and reliability of the assessment, and to provide a solid foundation for rendering care and evaluating the resident's response to services. To do this properly, clinicians must complete the MDS and utilize the RAPs according to the instructions provided by HCFA in the "Long Term Care Resident Assessment Instrument User's Manual, Version 2.0" published October 1995; in the "Long Term Care Resident Assessment Instrument Questions and Answers, Version 2.0" document published as an adjunct to the User's Manual in August 1996; and in other official publications on HCFA's MDS 2.0 web site at www.hcfa.gov/medicaid/mds20.

If the information provided by a Fiscal Intermediary or "Medicare reimbursement representative" differs from that found in the RAI User's Manual or other official HCFA sources related to SNF PPS or regulatory quality programs, it should be discounted in favor of the official HCFA source. HCFA staff responsible for the SNF PPS program work closely with the HCFA MDS and quality program staff to ensure that the SNF PPS system is based on the "clinical" rules that all facility staff should be familiar with. If you still have questions on a particular issue, consult your State's RAI Coordinator.

Regarding payment system incentives, since the advent of PPS, there may have been a tendency for some facilities to creatively push the boundaries of MDS item definitions to maximize coding of particular MDS items, slide the resident into a higher RUG category, and thereby increase payment to the facility. This practice will ultimately lead to problems. MDS data will increasingly be used within regulatory quality monitoring activities. The accuracy of each facility's MDS data will also be more closely scrutinized as HCFA implements new MDS validation activities, Fiscal Intermediary Medical Review activities, and Program Safeguard activities, raising the risk that facilities who routinely push the bounds of MDS item definitions will be cited or fined for submission of inaccurate MDS data.

Many providers have already come to the conclusion that the most efficient and practical way to complete the MDS is to do so using the "clinical" rules put in place when the RAI system was originally implemented in 1990, and that the changes in

practice required to “game” the system are not worth the resulting remuneration in the short-term. Indeed, the same “clinical” rules govern use of the RAI, regardless of which type of system the data is used to support. Adherence to the “clinical” rules will provide an accurate picture of the resident, which should ensure that the facility receives a fair and equitable rate of reimbursement and is also evaluated fairly in activities that use MDS data to focus regulatory quality monitoring. Perhaps most importantly, accurate MDS coding is important for the benefit of the residents, as their care plans are derived from the MDS assessment.

QUESTION 2 - 2: Sometimes surveyors or auditors tell our facilities that assessors cannot code anything on the MDS if there is no supporting documentation elsewhere. This is creating a tremendous documentation burden for our staff. It was our understanding that the MDS may be considered a “source” document. Please explain.

The MDS is a clinical assessment. As such, it is a primary source document and is considered part of the clinical record by federal regulation. Documentation is currently federally required to substantiate coding of certain MDS items, as specified in the Long Term Care Resident Assessment Instrument User’s Manual for version 2.0, October, 1995. There is no federal requirement for a second source of documentation elsewhere in the record to substantiate the resident’s status for each and every MDS item. Such “duplicate documentation” is in conflict with the original intent of the RAI system, imposes unnecessary, and may distract clinical staff from resident care.

However, completion of the MDS does not obviate the facility's responsibility to document a more detailed assessment of particular issues of relevance for the resident (e.g., as might be discovered through the RAPs, or by assessing areas not included or covered in sufficient depth on the MDS). Facilities are also required to document the resident's care and response to care during the course of the stay, and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment or quarterly review and related care issues. Bear in mind that government requirements are not the only reason for clinical documentation. The MDS system has codified some documentation requirements into a standard format. In addition, clinical documentation that contributes to identification and communication of residents’ problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals.

Some States may have regulations that require supporting documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the Medicaid system. Check with your State to clarify the requirements.

In the SNF PPS system, the MDS is viewed as a primary data source and duplicative

documentation is not required. However, information contained in the clinical record must be consistent and cannot be in conflict with the MDS. Additionally, there must be documentation that substantiates the resident's need for post-acute SNF services and his/her response to those services.

QUESTION 2 - 3: What is the significant change assessment requirement for residents with end stage disease? The RAI User's manual (page 2-11) states that a significant change assessment is optional if there is an end of life issue (J5c "End stage disease" is checked). If a patient has a diagnosis in Section H of brain tumor, but J5c is not checked as "End stage disease" and the patient's condition suddenly deteriorates (e.g., was walking on the unit and suddenly is unable to walk), is a significant change assessment appropriate, as the person's functional status and care plan needs have changed dramatically?

A significant change assessment is required in this scenario, and would be required even if the facility had indicated the resident had an "end stage disease" in item J5c. The key issue in determining whether a significant change assessment is required for individuals with a terminal condition is whether the change in condition is an expected, well-defined part of the disease course, and is consequently being addressed as part of the overall plan of care for the individual. In this case, let's assume the resident's brain tumor was considered terminal (e.g., he had fewer than six months to live). Despite the "terminal" diagnosis, a significant change assessment would be warranted clinically because of the likelihood that the unexpected and abrupt functional decline would result in multiple new care issues. He would now probably require assistance with certain ADLs; the new loss of independence might be associated with mood or behavioral problems; and his loss of mobility may impact his appetite/nutritional status, ability to participate in activities, and even place him at risk of a pressure ulcer. On the other hand, if the resident had been on a steady downhill course and had lost his mobility very gradually as an expected consequence of the end-stage disease, a significant change assessment may not be clinically warranted, if the facility reassessed his condition on a day-to-day basis and modified his careplan accordingly.

To restate, the guidance in the RAI User's Manual on page 2-11 was not intended to provide a *way out* of doing significant change reassessments for terminally ill individuals, if such a reassessment is clinically warranted. Rather, the guidance was intended to eliminate the need for facilities to adhere to the narrowly defined situations listed in the User's Manual in which a significant change reassessment is required, but does not necessarily benefit the resident, as the facility's own assessment and care planning practices for an expected course of illness are already resulting in high quality, individualized care that is being reevaluated on a daily basis. If a resident who is terminally ill experiences the new onset of symptoms or a condition that is not part of the expected course of deterioration, a significant change reassessment is required.

QUESTION 2 - 4: What are the rules for RAI assessment and reassessment for respite stays? Does an RAI assessment have to be done for a person admitted for respite care?

A RAI assessment must be completed for any individual whose stay in a certified long-term care facility exceeds 14 days. There are no exceptions to this statutory requirement. Federal requirements pertain to all individuals admitted to a certified facility, regardless of the type of services they are receiving. If a facility provides respite services for an individual for longer than 14 days, an RAI assessment is required. This is true even in situations when the original plan called for a stay of 14 days or less, but the resident actually stayed longer than 14 days. Even for stays shorter than 14 days, the facility must still have a mechanism in place to identify, communicate and meet resident's needs. In this case, the facility must also complete and submit an MDS Discharge Tracking form (MDS Item AA8a = 08, (discharged prior to completing initial admission assessment) unless an initial admission assessment was optionally completed.

QUESTION 2 - 5: Can an old (prior) assessment be used when an individual resident is readmitted for respite care after several months? Should a reentry form be completed since the resident was once in the system?

When a prior resident is readmitted for respite care, the facility must follow the standard requirements for completion and submission of assessments and tracking forms.

If the resident was discharged with "return not anticipated" (MDS Item AA8a = 06), then a Reentry Tracking Form should not be completed upon the resident's return, and an old (prior) assessment cannot be used. Whenever a resident was discharged with "return not anticipated", then he/she must be treated as a new resident upon return, and an Initial Admission comprehensive assessment must be completed and transmitted to the State, if the stay exceeds 14 days.

If the resident experienced a significant change in clinical status since his/her last admission, then a comprehensive reassessment using the RAI would be required if the current stay exceeds 14 days. If more than 92 days elapsed (R2b to R2b) since the last assessment or quarterly review was completed and the current stay exceeds 14 days, then a new quarterly review must be completed and transmitted. If more than a year elapsed (VB2 to VB2) since the last comprehensive RAI was completed (including MDS and RAPs) and the current stay exceeds 14 days, then a comprehensive RAI must be completed and transmitted.

At the time of discharge, a discharge tracking form must be completed and transmitted regardless of length of stay. If the stay is less than 14 days, then the facility should complete and transmit a Discharge Tracking Form (MDS Item AA8a = 08), "discharged

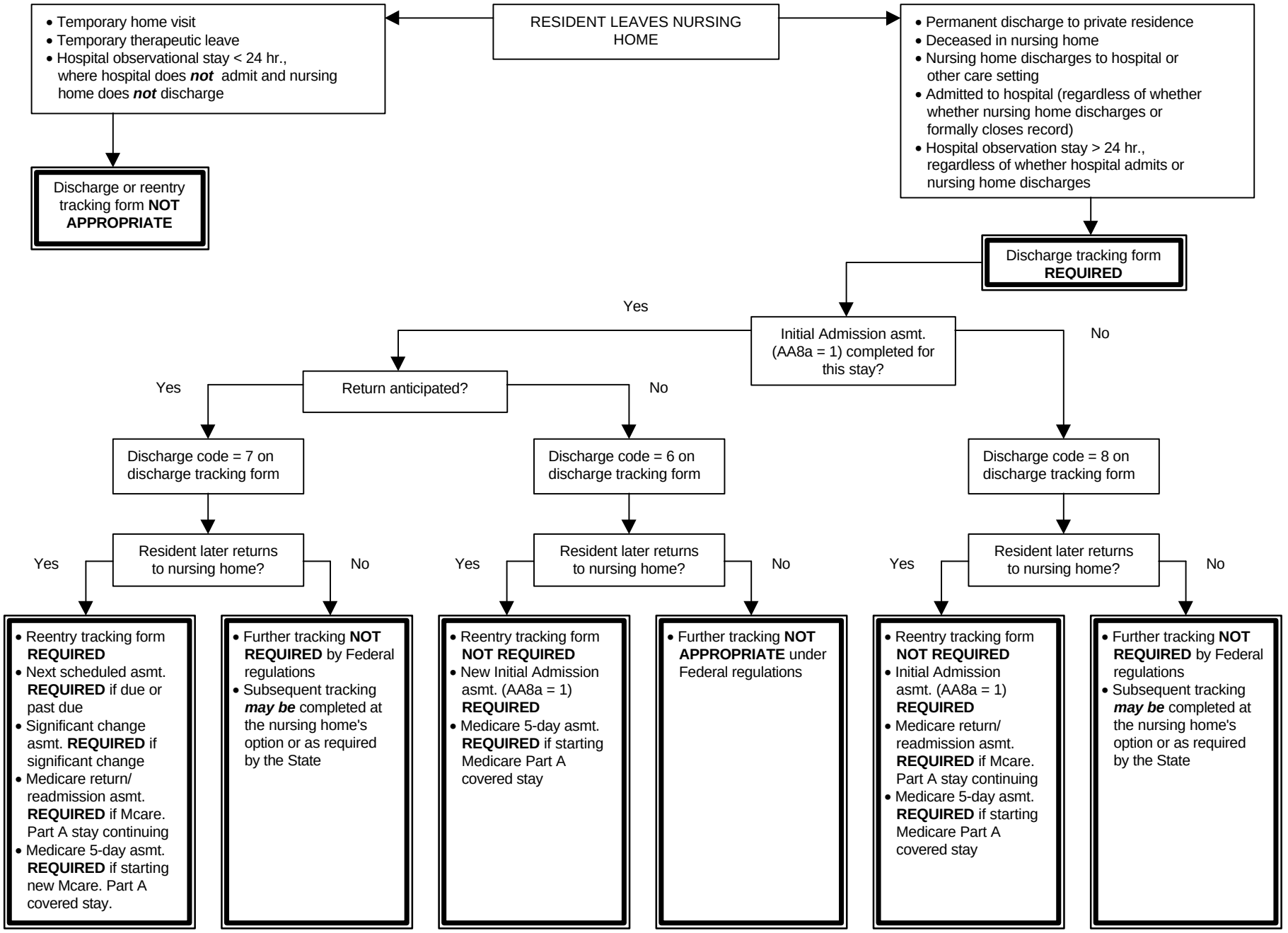
prior to completing initial assessment", unless an Initial Admission assessment was optionally completed by the facility, in which case the facility would code MDS Item AA8a as 06 or 07, whichever is appropriate. If at the time of discharge, the family indicates that they are likely to request respite care again for the same resident within the next three months, the facility may code "discharge--return anticipated" (MDS Item AA8a = 07) on the Discharge Tracking form. Then, upon the resident's return, the facility should complete and transmit a Reentry Tracking form, which simplifies the assessment requirements upon the resident's return. If the resident's return is not anticipated, then the facility should code "return not anticipated" (MDS Item AA8a = 06) on the Discharge Tracking form.

Keep in mind that whenever any resident's stay does not exceed 14 days (regardless of whether the stay was for respite care), even though an RAI assessment may not be required, the facility is still obligated to have a process in place to identify the resident's needs, and to initiate a plan of care to meet the resident's needs upon or shortly after admission.

QUESTION 2 - 6: Please clarify the requirements for Discharge and Reentry Tracking forms.

The following flowchart illustrates the requirements for Discharge and Reentry Tracking forms in various scenarios. We have received feedback from the industry that this chart is useful as a reference as well as a training tool. The flowchart is published as Exhibit 260 in our State Operations Manual.

State Operations Manual: Exhibit 260
MDS 2.0 DISCHARGE AND REENTRY FLOWCHART



QUESTION 2 - 7: For the MDS items looking at functional change as "compared to 90 days ago or since the last assessment if less than 90 days," does the "last assessment" include PPS assessments or only OBRA required assessments?

Yes, PPS assessments are included. For example, the 14-day assessment would use the 5-day PPS assessment as a point of comparison.

QUESTION 2 - 8: Can the RAPS and care plan be completed with either the 5-day or 14-day assessment to satisfy both the payment and the clinical MDS requirements?

Yes. The federal requirements for SNF PPS call for completion of a full MDS at (approximately) day 5 and day 14 of a resident's Medicare Part A covered stay. The federal requirements for clinical assessments apply to all residents in Medicare or Medicaid certified nursing homes and call for completion of a comprehensive assessment (MDS plus RAPs) within 14 days of admission, and completion of a care plan within 7 days thereafter. There is not a federal requirement for RAPs to accompany a PPS assessment. However, nursing home staff may conserve work by completing one assessment that satisfies both sets of requirements. For example, completing either a 5-day or a 14-day PPS assessment that is also an Initial Admission assessment, as long as that assessment satisfies all of the clinical and payment requirements; includes all sections and items required under both regulations; and meets the timing requirements of both regulations.

Questions on Items in MDS Section AA of the Basic Assessment Tracking Form

QUESTION 2 - 9: How do you code race and ethnicity (item AA4) in situations that are not clear-cut? For example, a resident from India does not appear to fit into any of the designated categories in AA4.

Item AA4 uses the race/ethnicity categories mandated by the Executive Office of Management and Budget (OMB) in 1996 when MDS version 2 was implemented nationally. OMB guidelines require self-identification of race/ethnicity. This means that the resident should be asked to select the category that most closely corresponds to her race/ethnicity from the list in AA4. If the resident is unable to respond, a family member should be asked to make the selection. If the resident is unable to respond and no family member is available, the assessor should assign whichever category they feel is most appropriate. Section AA, including the race/ethnicity category, will

likely be refined in version 3.0 of the MDS to accommodate new HIPAA requirements and any additional new federal guidelines.

In response to your specific question, an individual of Indian (i.e., Far East) descent is generally considered to be Asian (AA4=2).

Questions on Items in MDS Section B

QUESTION 2 - 10: For MDS Item B4 (Cognitive Skills for Daily Decision-Making), please clarify the differentiation between coding responses "2" (Moderate Impairment) and "3" (Severe Impairment).

The key difference is basically the frequency of decisions made by the resident. If the resident “rarely or never” made decisions, despite being provided with opportunities and appropriate cues, Item B4 would be coded as “3" Severely Impaired. If the resident attempts to make decisions, although poorly, code "2" for Moderately Impaired.

QUESTION 2 - 11: How should the following examples be coded for MDS Item B4 “Cognitive Skills for Daily Decision-Making”?

1. **If a resident seems to have severe cognitive impairment and is non-verbal, but usually clamps his mouth shut when offered a bite of food, would the resident be considered moderately or severely impaired?**

2. **If a resident does not generally make conversation or make his needs known, but replies "yes" when asked if he would like to take a nap, would the resident be considered moderately or severely impaired?**

These examples are similar in that the residents are primarily non-verbal and do not make their needs known, but they do make basic verbal or non-verbal responses to simple gestures or questions regarding care routines (e.g., comfort). More information about how the resident functions in his environment is needed to definitively answer the questions. From the limited information provided about these residents, one would gather that their communication is only focused on very particular circumstances, in which case it would be regarded as “rarely/never” in the relative number of decisions a person could make during the course of a week, and B4 would be coded as “3", Severe Impairment. The assessor should determine if the resident would respond in a similar fashion to other requests made during the 7-day observation period. If such “decisions” are more frequent, the resident may be only moderately impaired or better.

Questions on Items in MDS Section C

QUESTION 2 - 12: If the resident is coded in item C4 (Ability to Understand Others) as "3" (Rarely or never understands), should the resident automatically be coded as severely impaired in daily decision making (item B4=3)?

No. The two areas of function are not always associated. For example, a person who rarely/never understands may speak a language other than that spoken by caregivers, or he/she may be profoundly hearing or vision impaired. A more thorough assessment must be done to determine the actual level of cognitive function.

QUESTION 2 - 13: Where do I code residents with communication problems related to Alzheimer's, Parkinson's and multi-infarct dementia?

Aphasia is a speech or language disorder caused by a disease or injury to the brain. This results in an impairment in the ability to comprehend or express language that may affect some or all channels of communication, including listening and reading, speaking, writing and gesturing. Residents with communication problems as a result of Alzheimer's, Parkinson's, or multi-infarct dementia, would be coded under Section C. Communication/Hearing Patterns. It should also be coded under item Ir, aphasia.

Questions on Items in MDS Section G

QUESTION 2 - 14: When coding MDS Item G2 "Bathing", do sponge baths count as a bathing activity? Is the coding of bathing restricted to a specified "bath day" where a shower or a tub bath is completed?

This item is intended to capture how much of the bathing activity a resident can perform for him/herself, and how much staff assistance is needed. The setting, or day of the week, is not a key factor. Sponge baths should be counted. Note that sponge baths are specifically mentioned in the Item description on the MDS form.

QUESTION 2 - 15: MDS Item G6a "Bedfast all or most of the time" is defined on page 3-99 of the RAI Manual as "Resident is in bed or in a recliner in own room for 22 hours or more per day . . . also includes residents who are primarily bedfast but have bathroom privileges." What if the resident was in their room more than 22 hours per day and spent a great deal of time in bed (per their choice) BUT was able to move independently in their room or even on the unit (they chose to remain in their room). They don't seem bedfast to me but the definition of bedfast does not address the issue of how much independence they have in mode of transfer. Does bedfast relate to how much transfer assistance they need to get in and out of a chair/bed and the location of that chair/bed during the 22 hours?

No. The concept of bedfast was meant to capture all residents who spend 22 hours or more in a bed or recliner in their own room regardless of their level of function. Immobility, whether innate or self-inflicted, places residents at risk for a myriad of clinical problems. For example, being bedfast may also be an indicator that a resident is withdrawn from others and suffers from depression.

Questions on Items in MDS Section H

QUESTION 2 - 16: The coding instructions at MDS Items H1a and b for Bladder and Bowel Continence state to "code the frequency with which the resident is wet and dry during the 14 day assessment period." Please define "wet". For a resident who wears an incontinence pad, if the pad is wet, but the resident's undergarment is dry, is the resident considered wet or dry? If the resident wears incontinence brief, and the brief is wet, but the outer garment is dry, is the resident considered wet or dry?

Determination of whether to code incontinence is not a matter of volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown. According to Dr. Courtney Lyder, Ph.D. a nationally recognized incontinence and pressure ulcer expert from Yale University School of Nursing, "Urinary incontinence is a major risk factor for pressure ulcer development. Hence excessive moisture (from stool and/or urofecal incontinence) can cause the skin to become macerated with less pressure needed to develop a Stage II pressure ulcer. In the presence of moisture, less pressure maybe required to develop an ulcer." Coding incontinence is a matter of acknowledging and recording a resident's incontinence problem on the assessment, and ensuring that the care plan derived from the assessment addresses the problem. If the resident's skin gets wet with urine, or if whatever is next to the skin (i.e., pad, brief, underwear) gets wet, it should be counted as an episode of incontinence - even if it's

just a small volume of urine, for example, due to stress incontinence. Any episode of incontinence requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or incontinence care plan. In addition, since incontinence is a problem that many residents are sensitive about, intervention involves maintaining dignity and life-style.

QUESTION 2 - 17: This inquiry pertains to MDS Item H2d, "Fecal impaction". In the course of an emergency room visit for a non-related matter, one of our residents had an abdominal CAT scan, which revealed "fecal impaction in the rectum…with clear upper colon." Prior to this, while at the nursing home, the resident had routine bowel movements at least every three days, and had been passing stools without hard stool being removed from the rectum. Is it appropriate to code "Fecal impaction" even though no stool was removed from the rectum and even though the resident was passing stools?

The RAI User's Manual defines fecal impaction as follows: "The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on abdominal x-ray in the sigmoid colon or higher, even with negative digital exam or documentation of daily bowel movement." The situation described in the above question meets this definition. Therefore, fecal impaction should be coded. According to Dr. Peter Toth, MD, PhD in an article entitled "Gastroenterology: Constipation and Fecal Impaction" in the University of Iowa Family Practice Handbook, 3rd Edition, Chapter 4, a fecal impaction is a firm, immobile mass of stool most often in the rectum but may also occur in the sigmoid or descending colon." It is also possible for stools to pass around an impaction. Item H2b must be checked whenever a fecal impaction was present during the 14-day assessment period, regardless of how the determination was made (e.g., digital rectal examination, x-ray, CAT scan or other method). In the presence of symptoms of fecal impaction, the facility is obligated to determine whether the resident is, in fact, impacted, and to provide appropriate treatment.

QUESTION 2 - 18: For MDS Items H3a "Any scheduled toileting plan" or H3b "Bladder retraining program", must the care plan include a list of specific times for the resident to be toileted? Or can the toileting schedule be more general, referring to times such as "upon arising, after meals, before bed and PRN"? Also, is there a requirement to maintain documentation of incontinence monitoring?

For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule

should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, such as those noted in this inquiry, as long as those routines occur around the same time each day. In most nursing facilities, the timing of such routines is fairly standardized. If that is not the case, then specific times should be noted. Regarding a bladder retraining program, the assessor should not check Item H3b for the type of toileting plan described in the above inquiry. This practice does not meet the rigors of a formal bladder retraining program as described in the Long Term Care RAI User's Manual on page 3-108 ("A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void…"). Good clinical practice dictates that any care plan be periodically evaluated and revised as necessary, which would include documentation of the resident's response to the program.

QUESTION 2 - 19: Should MDS Item H3d "Indwelling catheter" be checked for a resident who had an indwelling catheter during the 14 day observation period, but the catheter was discontinued before the end of the 14 day period?

Yes. Item H3d should be checked if a resident has, or has had, an indwelling catheter at any time during the 14 day observation period.

Questions on Items in MDS Section I

QUESTION 2 - 20: Regarding Item I2g, "Septicemia", if a resident has a recorded diagnosis of sepsis, and a blood culture has been drawn, but the results are not yet available, should Septicemia be coded?

Once the blood culture has been ordered and drawn, a physician's working diagnosis of septicemia can be coded at Item I2g, provided that the physician has documented the septicemia diagnosis in the resident's clinical record.

QUESTION 2 - 21: The RAI User's Manual indicates that lab results are required in order to code a urinary tract infection (UTI) to be coded at Item I2j. Recent medical literature indicates that colonized MRSA can be present even in the absence of symptoms. A physician might order antibiotics, without ordering labs, when a resident with colonized MRSA experiences symptoms of a UTI. Are lab results required in order to code a UTI at Item I2j?

Once a urine culture has been done, a physician's working diagnosis of UTI can be

coded at Item I2j. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record.

In response to your question regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

> "A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different even if the patient is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism."

Questions on Items in MDS Section J

QUESTION 2 - 22: Should the following situations be recorded as "falls" in Items J4 "Fell in past 30 days", or J5 "Fell in past 31 – 180 days": a) resident lost their balance, and was lowered to the floor by staff; b) resident fell to the floor, but there was no injury; c) resident was found on the floor, but the means by which he/she got to the floor was unwitnessed; d) resident rolled off a mattress that was on the floor.

a) An episode where a resident lost his/her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall.
b) The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall.
c) When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred.
d) The distance to the next lower surface (in this case, the floor) is not a factor in determining whether a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, this is a fall.

The point of accurately capturing occurrences of falls on the assessment is to identify and communicate resident problems/potential problems, so that staff will consider and implement interventions to prevent falls and injuries from falls. In the instance of a resident of rolling off a mattress that is close to the floor, even though this is still recorded as a fall, it might be true that staff have already assessed and intervened, and that placing a bed close to the floor to avoid injuries from falls is the intervention that best suits this individual resident.

Questions on Items in MDS Section K

QUESTION 2 - 23: Should residents who have chewing or swallowing problems, and who are on special diets (e.g., pureed diet or thickened liquids), be coded at MDS Item K1a and K1b as having a chewing or swallowing problem when, due to the special diet, the chewing or swallowing problem was not observed during the assessment reference period?

A general rule of thumb in the MDS system is that items are coded based on the objective performance of the resident during the observation period dictated by the Assessment Reference Date. If special dietary modifications allowed the resident to consume meals without experiencing chewing or swallowing problems during the observation period, then no such problems should be coded on the MDS. However, good clinical practice dictates that the documentation of the need for the special dietary modifications (i.e., the presence of chewing or swallowing problems and any evaluation to determine the underlying etiology) would be found in the resident's clinical record.

QUESTION 2 - 24: If a resident is receiving nutrition via a feeding tube or IV because of dysphagia, should Item K1b "swallowing problem" be checked?

Yes.

QUESTION 2 - 25: The coding instructions in the RAI User's Manual for MDS Item P1ai specifically states "includes nasopharyngeal or tracheal aspiration". Does this instruction refer to the type of suctioning? Or does it describe what is being suctioned (i.e. nasopharyngeal or tracheal secretions or fluids)? Is this a complete list, or just examples of the kinds of suctioning that can be coded at P1ai? Can oral suctioning be coded at this Item?

The only types (methods) of suctioning that may be coded at Item P1ai are

nasopharyngeal or tracheal. This item does not pertain to the type of secretions that are being suctioned. Oral suctioning should not be coded at this Item.

QUESTION 2 - 26: Where should Total Parenteral Nutrition (TPN) be coded? Is it coded as a medication? Is a fat emulsion counted separately from the protein/carbohydrate mixture if it is administered separately? Are additives, such as electrolytes and insulin, counted separately, or are they considered to be part of the TPN?

The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in K5a and K6a. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are counted as separate medications in Section O1. For example, 20 mEq of KCl, added to the TPN solution, is counted as one medication. 10 Units of regular insulin and 40 mEq of KCl added to the TPN solution would be counted as two medications in O1.

QUESTION 2 - 27: Should Item K5a "Parenteral/IV" be checked for IVs administered at a "keep vein open" (KVO) rate?

Yes. The RAI User's Manual specifies on page 3-130 that this category includes IV lines with fluids running at KVO. In addition, the resident's calorie intake by IV fluids must be coded at Item K6a, and average fluid intake at Item K6b, for the 7 day assessment period.

QUESTION 2 - 28: Should the amount of heparinized saline solution used to flush a heparin lock be included in Item K6b?

No. IV flushes are not included in this calculation. If no other fluid is being administered intravenously, Item K6b should be coded 0 (none).

QUESTION 2 - 29: The RAI User's Manual instructions on page 3-133 for Item K6b "average fluid intake per day by IV or tube in last 7 days", specifies to "Code for the average number of cc's of fluid the resident received per day by IV or tube feeding." The instructions call for adding the total amount of fluid received each day and dividing by 7 to arrive at the average fluid intake per day. The example in the RAI User's manual shows a resident who received IV fluid for all 7 days in the assessment period. What about a resident who received IV fluid on only 3 of the 7 days in the assessment period? In that case, should the total amount of fluid over the 7 day period be divided by 3 (the number of days the resident actually received IV fluid), or by 7 (the number of days in the assessment period)?

The answer to this inquiry is provided in the RAI User's Manual, on page 3-133. The process states to add up the total amount of fluids by IV or tube feeding and "Divide the week's total fluid intake via IV/tube feeding by *7*". So *divide the week's total by 7, even if fluids were administered fewer than 7 days in the assessment period*. The example below illustrates a scenario in which a resident received IV fluid 3 out of 7 days in the assessment period:

Example: The resident received the following amounts of IV fluid on three of the 7 days of the assessment period.

Sun.	1000cc
Mon.	1000cc
Tues.	500cc
Wed.	0cc
Thurs.	0cc
Fri.	0cc
Sat.	0cc
Total:	2500cc Divided by 7 = 357cc/day

Code "1" for 1 to 500 cc/day

Questions on Items in MDS Section M

QUESTION 2 - 30: If a resident receives a laceration that is severe enough to require suturing or butterfly bandaging, should the laceration be coded as a surgical wound at MDS Item M4g?

Yes. A wound as described in the above inquiry would be coded as a surgical wound in M4g. Subsequent care would be coded at MDS Item M5f, provided the care meets the item coding definition.

QUESTION 2 - 31: Where in Section M (Skin Condition) should an ulcerated area over a plantar's wart on the foot be coded?

Record such ulcers at MDS Item M6a only (Resident has one or more foot problems...). This should *not* be coded at Item M1 (Ulcers).

Questions on Items in MDS Section O

QUESTION 2 - 32: Are garlic or fish oil capsules, or doctor-prescribed/nurse-dispensed herbal remedies, such as St. John's wort or gingko biloba considered to be medications? If so, should they be counted as medications at MDS Item O1 (Number of Medications)?

No. Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). They are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted at MDS Item O1. These substances may be coded at MDS Item K5f, provided they meet the definition of dietary supplement for this Item. Keep in mind that, for clinical purposes, it is important to document a resident's intake of such substances elsewhere in the clinical record and to monitor their potential effects, as they can interact with other medications. More information on dietary supplements identified by the FDA can be found at the following web-site: www.nih.gov/health/.

QUESTION 2 - 33: If a resident receives medications off-site, for example, while at a dialysis unit outside of the facility or at an outpatient chemotherapy center, should these medications be included in the medication count at MDS Item O1? These medicines are generally not included on the physician's order sheet that is used by the nursing staff.

All medications used by the resident in the 7 day assessment period need to be counted in section O. All medications administered off-site (e.g., while receiving dialysis or chemotherapy) must be considered when completing MDS Items O1, O2, O3, and O4. The facility is responsible for communicating with the outpatient site to identify the use of any medications received while the resident was under their care, and for monitoring the effect, including any adverse effects, of medications after the resident's return to the facility.

QUESTION 2 - 34: If a resident is taking a combination drug such as Corzide (which contains a diuretic and a beta-blocker), should this be counted as one or two medications in Section O of the MDS (Medications)?

Combination products are counted as one medication at MDS Items O1-O3.

QUESTION 2 - 35: Should administration of Epogen be recorded in Section O of the MDS (Medications)?

Yes. Administration of Epogen should be recorded in several places in Section O, depending on its route of administration and date of initiation. It should be counted at MDS Item O1 (Number of Medications), and if it was initiated during the last 90 days, it should also be indicated at MDS Item O2 (New Medication). If the Epogen was given sub-cutaneously, also record it in item O3 (Injections). If it is given intravenously, it should be indicated at MDS Item P1a-c (IV medication).

QUESTION 2 - 36: Is subcutaneous Computer Assisted Dispatch (CAD) pump service coded in Section O of the MDS (Medications)?

Yes. Code this at MDS Item O3 (Number of days injections of any type received during the last 7 days).

QUESTION 2 - 37: Is the small amount of heparin included in a saline solution used to irrigate a "heparin lock" (for the purpose of keeping a vein open) counted in Section O?

No, it is not counted in any of the Section O items.

Questions on MDS Items in Section P

QUESTION 2 - 38: Megace is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If it is not being prescribed as a cancer treatment, but to stimulate appetite, should it still be coded as chemotherapy in item P1aa?

No. The resident is not receiving chemotherapy. Section P, Special treatments and Procedures, is for the collection of information regarding treatments and procedures received during the last 14 days. Although Megace is classified as an anti-neoplastic agent, it is not being provided in this case as a chemotherapy treatment, and so it should not be coded at MDS Item P1aa (Chemotherapy). The Megace should be counted in the number of medications received at MDS Item O1. Facility staff are

responsible for monitoring the effects, including any adverse effects, of the drug.

QUESTION 2 - 39: Does Hemofiltration/SCUF/CAVH count as a dialysis treatment (Item P1ab)?

Although they are not included in the definition of dialysis treatment specified on page 3-149 of the RAI Users' Manual, these are types of dialysis. Record treatments of "Hemofiltration," Slow Continuous Ultrafiltration (SCUF) and Continuous Arteriovenous Hemofiltration (CAVH) in MDS Item P1ab (Dialysis).

QUESTION 2 - 40: In assessing a potential resident for admission to the facility, we learned that the resident is receiving pain control via an epidural pump. Where would this information be coded on the MDS at Item P1ac (IV Medication)?

MDS version 2 does not contain a specific item for recording the use of an epidural pump. Record the use of an epidural pump in item P1ac (IV medication). Epidurals are similar to IV medications in that they must be monitored frequently and involve the continuous administration of a substance.

Additionally, each type of medication administered through the epidural should be counted in item O1 (Number of Medications), and if initiated in the last 90 days should be recorded in item O2 (New Medications). This issue will also be considered for inclusion as a specific item in version 3 of the MDS.

QUESTION 2 - 41: What is the definition of a transfusion at MDS Item P1ak?

Refer to page 3-149 of the RAI User's Manual, which provides instructions to include "blood or blood products (e.g., platelets) when coding this item." The term transfusion implies that these products are administered directly into the blood stream.

QUESTION 2 - 42: Should MDS Item P1ag (oxygen therapy) be checked when the resident receives hyperbaric oxygen for wound therapy?

No. The spirit of this Item was to record use of oxygen for respiratory oxygenation. This section of the MDS is not intended for capturing wound care information, even if that care involves the use of oxygen. There is no specific MDS Item to capture hyperbaric oxygen, however, we are seeing an increase in its use, and will consider this in the course of developing version 3.0 of the MDS.

QUESTION 2 - 43: Residents with sleep apnea are undergoing treatments with a mask-like device that is being used to keep the airway open during sleep. Can this be coded as a ventilator or a respirator at MDS Item P1al?

No. According to the American Academy of Otolaryngology-Head and Neck Surgery, Inc., a CPAP (Continuous Positive Airway Pressure) device delivers air into your airway through a specially designed mask or pillows. The mask does not breathe for you; the flow of air creates enough pressure when you inhale to keep your airway open.

Ventilators are sometimes used to deliver this type of non-invasive ventilation when CPAP or BIPAP machines are not available. In these cases, the ventilator is merely providing air, not traditional life support via invasive measures and does not require the same level of intensity of car that life support ventilation demands.

QUESTION 2 - 44: Please clarify the instructions for Items P1b: a-e (Therapies) on page 3-150 of the User's Manual, which refer to "Therapies that occurred after admission to the nursing home...". Does this also include therapies that occurred "post-readmission"?

The spirit of this instruction is to include only therapies provided once the individual is actually living/being cared for at the facility. Therefore, post-readmission therapies should be included in this category. Do NOT include therapies that occurred while the person was an in-patient at a hospital or recuperative/rehabilitation center or other nursing home, or a recipient of home care or community-based services.

QUESTION 2 - 45: Should time spent by a therapist in evaluation of a resident be counted at MDS Item P1b (Therapies)?

This question was previously answered in # 114 of HCFA's MDS 2.0 "Questions and Answers" publication (1997). A therapist's initial evaluation time cannot be counted, but a subsequent evaluation conducted as part of the treatment process would be counted.

QUESTION 2 - 46: Can the use of a Constant Passive Motion (CPM) machine be captured under restorative nursing at MDS Item P3?

The CPM device would be recommended by the Physical Therapist and ordered by the resident's physician. Physical therapy staff may demonstrate application and use of the device to the nursing staff. The device is usually set up in the evening by the nursing staff. Monitoring of the device during the night, and documentation of the application of the device and effects on the resident are done by the nursing staff. If the application and monitoring of the CPM device takes at least 15 minutes (or more)

per day, then the nursing staff may enter the number of *days* in P3a. If the application and monitoring of the CPM device takes less than 15 minutes per day, MDS Item P3a would be coded as “0”.

QUESTION 2 - 47: Should an evaluation/visit by a licensed psychologist (Ph.D.) be counted as an MD visit in MDS Item P7 (Physician Visits)? Should orders from a Ph.D. psychologist be counted in MDS Item P8 (Physician Orders)?

No. The definition (pages 3-160 and 161) of "Physician" for both these items includes "MD, osteopath, podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant or nurse practitioner working in collaboration with the physician." Evaluations by a Ph.D. psychologist should be coded in item P2b (Evaluation by a licensed mental health specialist in the last 90 days); therapy provided by a psychologist should be coded in item P1b(e), (Psychological therapy).

QUESTION 2 - 48: If a resident goes to a hospital for dialysis treatment, or for radiation therapy and is seen by a physician, can this be coded at MDS Item P7 (Physician Visits)?

If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded in P7. Documentation of the physician's evaluation should be included in the clinical record. The physician’s evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.

QUESTION 2 - 49: Can abnormal accu-check results be counted as abnormal lab values under P9?

Yes. Abnormal blood glucose levels, including levels obtained via finger-sticks, should be counted at MDS Item P9.